

PENN CHRISTIAN ACADEMY

Norristown Area School District Student Information Sheet

For all **NEW Kindergarten and Older Enrolling Students**

Student's Name _____ Date of Birth ____/____/____

Address _____
(street) (town) (state) (zip)

Parent Names _____
(mother) (father)

Parent With Whom Child Resides _____ Home Tel. _____ Work or Cell # _____

Medical Insurance _____
(company/carrier) (policy #)

Dental Insurance _____
(company/carrier) (policy #)

Please Check Any Problem Your Child Has/Had

- | | | |
|-----------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Allergy: | <input type="checkbox"/> Dental | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Food | <input type="checkbox"/> Eating/Feeding | <input type="checkbox"/> Physical Limitations |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Frequent Colds/Sore Throats | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Skin Rash/Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems (Murmur) | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tires Easily |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Kidney Condition | <input type="checkbox"/> Toileting Problem (Wetting/Soiling) |
| <input type="checkbox"/> Behavior/Emotional | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle/Bone/Joint | <input type="checkbox"/> Vision Difficulties |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Urinary Tract Infection |

Explain any item checked above _____

Describe any serious illnesses, accidents or operations your child has had _____

List any/all limitations and restrictions _____

List any medications your child takes _____

(signature)

(relationship to signer)

(date)

CHILD'S GROWTH AND DEVELOPMENT
For all NEW Kindergarten and Older Enrolling Students

Child's Name _____

Birth Weight _____ / _____
 (pounds) (ounces)

	Yes	No	Comments
Illness of mother during pregnancy			
Labor and/or delivery extremely short			
Labor and/or delivery extremely long			
Heavily sedated during labor or delivery			
Baby born prematurely			
Baby had feeding problems			
Child had toilet training problems			

Child is (check one): ____ right handed ____ left handed. Child spoke a few words at _____ months.
 Child sat without support at _____ months. Child spoke a few sentences at ____ months.
 Child walked alone at ____ months. Child toilet trained (bowels) at _____ months/ (bladder) at ____ months.

FAMILY HISTORY

Is there a history of:

	Yes	Relationship
Allergies		
Asthma		
Cancer		
Diabetes		
Hearing Impaired		
Heart Disease		
High Blood Pressure		
Kidney Condition		
Seizure		
Tuberculosis		
Vision Problems		

PEDIATRICIAN or FAMILY DOCTOR

Dr. Name _____ Address _____ Tel. # _____

PREVIOUS SCHOOL INFORMATION

Last School Attended _____ Address _____

Are there any areas of concern or information that would be helpful to school staff ? _____

 (signature)

 (relationship to student)

 (date)

PENN CHRISTIAN ACADEMY

Norristown Area School District Health Services

School Health Services and Student Health Records

Parent Memorandum of Understanding

For all **NEW Kindergarten and Older Enrolling Students**

Student Name _____ Date of Birth ____/____/____
Last First Middle

I *understand* that the Norristown Area School District Health Services staff will work with my child and me to insure wellness and good health.

I *understand* that the Norristown Area School District provides school health services as required by the School Code and Department of Health Regulations which include:

- Vision Screening
- Review of Immunization Records
- Height and Weight
- Maintenance of School Health Records
- Scoliosis (grades 6 – 7) Hearing Screening (grades K – 3, 7 & 11)
- Dental Health Education (grades K – 8)
- Weekly Fluoride Mouth Rinse Program (grades 4 & 5)
- Dental Screening by the Hygienist (grades K, 3, 6, & 8)

I *understand* that if I inform the school nurse that I am not able to provide a private physical for my child, the medical examination required by the School Health Act will be given by the School Physician.

I *understand* that I will be notified of recommendations for further evaluations as a result of the screenings or examinations.

I *understand* that the information I give to the school nurse is important for the school staff to understand the health and education of my child.

I *understand* that the information will be kept confidential by the School Health staff and may be shared with other professionals in the school *only* when it is required as part of a comprehensive evaluation and in the best interest of the child's health and education.

Signature of Parent/Guardian

Date

Signature of Nurse

Date

Penn Christian Academy

Norristown Area School District

Pediatric Tuberculosis Screening Questionnaire

For all NEW Kindergarten and Older Enrolling Students

Child's Name: _____
Last First

Chart #: _____

Please answer the following questions by circling Yes or No.

Has your child had any contact with a case of TB?	Yes	No
Was any household member including your child, born in or traveled more than a year to areas where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)?	Yes	No
Does your child have regular (e.g., daily) contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Yes	No
Does your child have HIV infection?	Yes	No

Reviewer's Signature _____ Date _____

Norristown Area School District

Administrative Office

For all **NEW Kindergarten and Older Enrolling Students**

Dear Parents/Guardians,

Physical examinations are required by Pennsylvania Law for students on entry to school (Kindergarten/First), and in Grades 6 and 11 in September. Dental examinations are required on entry to (Kindergarten/First).

Parents are to have these examinations done by their family physician and dentist. It is felt that the family physician and dentist have a better knowledge of the past medical history of the child and are in the best position to recommend treatment of any medical problem.

The following Private Physician's Report of Physical Examination and Private Dentist's Report of Examination of a pupil of school age **must** be completed and returned to the School nurse by the first day of school.

Cordially,

Certified School Nurse

Note: The mandatory physical and immunization may be completed by your family Physician or

1. The Montgomery County Health Department, 1430 DeKalb Street, Norristown, 610-278-5145 (servicio en Espanol: 1-800-344-7889; TTY_Deaf Access; 1-800-234-7889). Immunizations only – no fee
2. Regional Health Care Center, 133 W. Main Street, 610-278-7787
Physical examinations and immunization – on a sliding scale fee
3. Visiting Nurse Association, 1109 DeKalb Street, 610-277-8911
Physical examinations and immunization – on a sliding scale fee

Norristown Area School District
Norristown, Pennsylvania 19403

Medical Department - Immunizations

For the 2007- 2008 School Year for Kindergarten Through Grade 4

Dear Parent or Guardian:

In accordance with the Pennsylvania State Law, it is required that all school children in the Commonwealth of Pennsylvania are to be protected against serious communicable disease and immunized as follows;

Diphtheria – Tetanus (D.T.)	Four or more doses	Properly Spaced – Dose # 4 to be given on or after the fourth birthday
Polio	Three or more doses	Properly Spaced
Measles, Rubella, Mumps	Two doses	Dose # 1 to be given on or after the first birthday
Hepatitis B	Three doses	Properly Spaced – Dose # 2 to be given 28 days after Dose # 1
Tuberculin Test	One Test	As indicated by the TB screening questionnaire
Varicella	One dose	Immunity from vaccine or written proof by a doctor of Chicken Pox Disease

These immunizations may be completed by your family physician or the County Health Department, 215-278-5145. Servicio en Espanol: 1-800-344-7432. TTY – deaf Access: 1-800-243-7889. There are no charges for these Immunizations at the County Health Department, but you must call for an appointment and take any immunization Record you have with you to the appointment.

The only exceptions to this law are those children who provide proof based on religious objections or medical reasons.

According to the law, the required immunizations must be completed **prior to entrance** into the school. Children will not be registered for school until proof of immunization is provided.

Please advise the school when your child has received the immunization listed above.

Cordially,

Certified School Nurse

 Phone Number

Norristown Area School District

Norristown, Pennsylvania 19403

ADMINISTRATION OF MEDICATION For ALL Families of New Students

Dear Parent/Guardian,

To insure maximum safety for all students, the Norristown Area School District has adopted procedures and guidelines regarding the administration of medication in school. Please review these procedures carefully. You may wish to discuss them with your child. Please assist us in making the school as safe as possible. Questions should be directed to the school nurse.

Procedure For Students Needing Medication During School Hours

All medication should be given at home by the parent/guardian whenever possible, such as at breakfast, after school, during the evening meal, and at bedtime. This allows for up to four doses of prescribed medication. No medication is to be sent to school unless it is prescribed by a physician for an acute illness, chronic condition, or emergency use.

Medication will be given to a student in school only when the following items are provided to the school nurse:

1. Physician's order stating name of student, name of medication to be given, amount, time, route, and the diagnosis.
2. Medication must have the current prescription label on the container. Any changes to the medication regimen requires a physician's note.
3. Parent/Guardian note giving approval for the medication to be given. A one week supply is adequate. For the safety of all children, parents must ensure the safe delivery of medication(s) to the school.

Students are not permitted to carry prescription(s) or over the counter medication(s) on their person. Students with medical conditions such as asthma or severe reactions to insect stings where immediate medical attention may be required are asked to inform the Principal/designee and/or the nurse of this existing condition and all appropriate precautions will be taken.

The school reserves the right to check with parent/guardians for the confirmation of any student medication needs.

Cordially,

Certified School Nurse

PD/wpc

Cc: Dr. Lisa A. Andrejko, Superintendent
Dr. Darlene Davis, Director, Pupil Personnel
Principals
Nurses

SN-7
Revised 11/03

NORRISTOWN AREA SCHOOL DISTRICT

For All NEW Students Grades Kindergarten – Grade 8

Dear Parent/Guardian:

The Norristown Area School District employs two certified Dental Hygienists who provide a state approved ***Dental Hygiene Services Program*** to all students. The Dental Health Programs planned for this year include the following:

- Kindergarten:** A dental evaluation will be provided for each child in addition to classroom dental health education.
- Grade 1:** Program on proper nutrition with an emphasis on home dental healthcare. Students will receive educational materials and toothbrush/toothpaste kits.
- Grade 2:** A dental evaluation will be provided for each child in addition to classroom dental health education to promote proper dental health habits. Students will receive toothbrushes and handouts.
- Grade 3:** Weekly Flouride Mouthrinse Program that requires written parental permission. Students will receive dental health instruction and educational materials.
- Grade 4:** Weekly Flouride Mouthrinse Program that requires written parental permission. Classroom instruction will be provided.
- Grade 5:** A dental evaluation will be provided for each child. Students will receive toothbrushes and dental health materials.
- Grade 6:** Preventive dental health education program will be conducted in accordance with student needs.
- Grade 7:** Preventive dental health education program will be conducted in accordance with student needs.
- Grade 8:** A dental evaluation will be conducted for all students accompanied by dental hygiene instruction/nutritional counseling.
- Special Education:** A dental evaluation will be provided for each child along with classroom education.

We are confident that all students will benefit from our Dental Hygiene Services Program and we are looking forward to working with the children in the months ahead.

If you have any dental concerns that you wish to call to our attention, please send a note to the school nurse and we will respond as quickly as possible.

School Dental Hygienist

For All NEW Students and All Students Entering Grade 6

Significant Medical Conditions (√)

	Yes	No	Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependencies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any medical problems or chronic diseases which require restriction of activity, medication, or which might affect his/her education? _____ If yes, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
Height (inches)				
Weight (pounds) BMI				
Pulse ()				
Blood Pressure /				
Hair/Scalp				
Skin				
Eyes/Vision				
Ears/Hearing				
Nose & Throat				
Teeth & Gingiva				
Lymph Glands				
Heart – Murmur, etc.				
Lung – Adventitious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (presence of Scoliosis)				

Date of examination: ____/____/____

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH**

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

For All NEW Students Grades Kindergarten – Grade 8

Name Of School: Penn Christian Academy

Date / /

Child's Name:

_____ (last) (first) (middle).

Address: _____ (street) (city) (county) (state) (zip)

Age: _____

Sex: _____

Grade: _____

REPORT OF EXAMINATION

TOOTH CHART

Right (1 - 8, 25 - 32)

Left (9 - 24)

Upper	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
Lower	31	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
Upper																	Upper
Lower																	Lower

Is the child under treatment? No Yes

Treatment Completed? No Yes

Date of dental examination / /

Signature of Dental Examiner

Print Name of Dental Examiner

Address